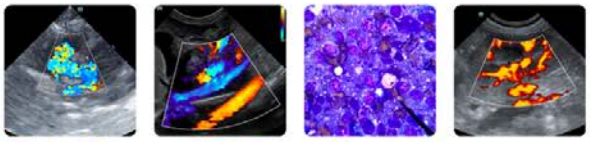


PATIENT

Carter Ossman

SPECIES

Canine

BREED

Collie x

SEX

Neutered Male

AGE

10

WEIGHT

41.1

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Jessica Green

HOSPITAL NAME

Stanglein Veterinary Clinic

REFERRING VET

Dr. Daniel Hoffman

INVOICE

75713

DATE

6/5/26

PRESENTING CLINICAL SIGNS

History of previous GI issues (recurrent HGE), but had been doing very well on his prescription GI diet(s) - discussed possible IBD vs. other; otherwise, appears to be a relatively healthy senior canine on physical examination

Abnormal PE/Chem/CBC/UA Results: 6/2/25 Abdominal Rad Study -- the stomach is moderately distended with what appears to be normal ingesta, and there is a small amount of feces in the distal colon that appears to be somewhat soft; the small intestinal loops appear plump/thickened, but no obvious forein bodies or obstructive patterns are noted; did not appreciate any obvious abdominal masses or significant organomegaly No significant changes are noted on his Chemistry. On the CBC, there is a mild to moderate elevation of his Eosinophils. 4DX NEG X4. UA unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder lumen volume is small, and walls are diffusely thickened most consistent with pseudohypertrophy. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal focal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present in left renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measured 5.39 cm. Right kidney measures 5.67 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left measures 1.57 cm in length x 0.45 cm at the caudal pole and 0.60 cm at the cranial pole. Right measures 1.41 cm in length x 0.52 cm in thickness.

Spleen

The spleen is normal in size, shape, and position. Parenchyma is diffusely slightly mottled with no specific nodules or masses seen.

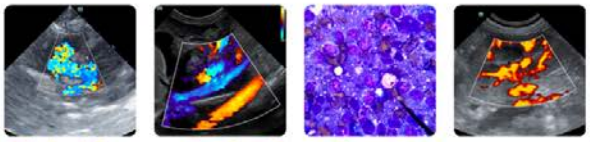
Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains a small volume of fluid. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.



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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is diffusely increased and wall layering is distinct with a prominent muscularis layer. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Diffusely thickened small intestines with prominent muscularis – consistent with suspected chronic enteropathy/IBD.
- Slightly mottled spleen – likely benign aging change.
- Mild aging renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Small intestinal changes are most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or other chronic enteropathy being the top differentials. GI lymphoma cannot be ruled out but is less likely. No overt neoplastic criteria were present in the bowel given that curvilnear layering is still intact. Ultrasound cannot differentiate between small cell lymphoma and inflammatory bowel disease and GI biopsies are recommended for definitive diagnosis, especially if there is a poor response to empirical efforts or recurrence of clinical signs after initial control. Endoscopic biopsy is less invasive but may miss lesions due to inability to obtain samples from all sections of the GI tract, especially the jejunum which is the most common site of development of disease. Surgical biopsies are more likely to be diagnostic but are more invasive. A GI panel (TLI/PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation. A baseline cortisol +/- ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Empiric treatment for IBD includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, GI support as needed (anti-nausea, appetite stimulant). Treatment with steroids (budesonide vs prednisolone) is often required – biopsies should be acquired prior to treatment with steroids. Steroids may ultimately be tapered to the lowest effective dose or discontinued in some cases.

Splenic changes are a common benign age related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. No significant disruption of architecture noted to suggest significant pathology. Fine needle aspirate could be considered to further characterize parenchymal changes if clinically indicated, especially if any weight loss is noted or for baseline cytological assessment.

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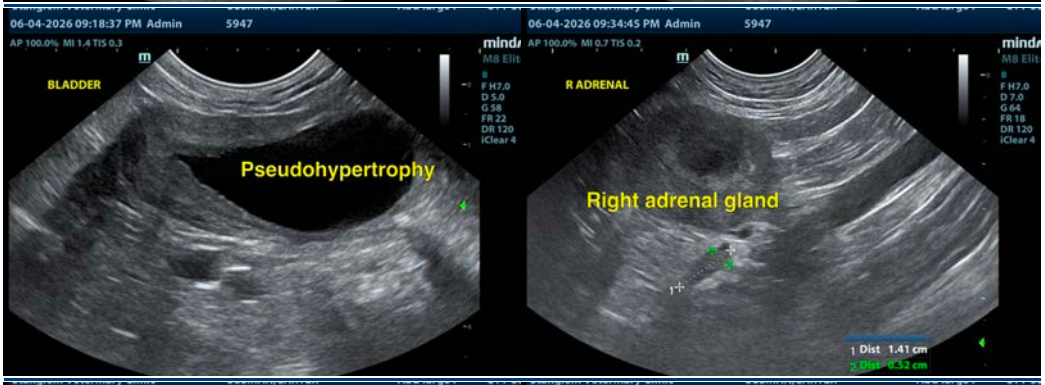

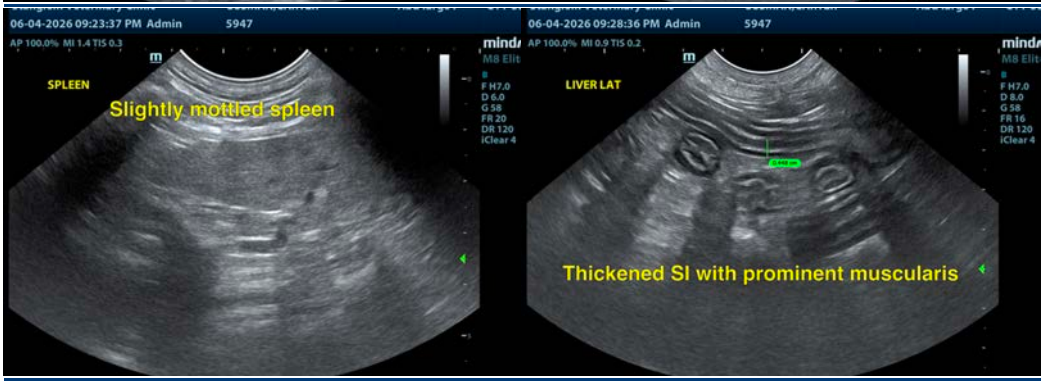

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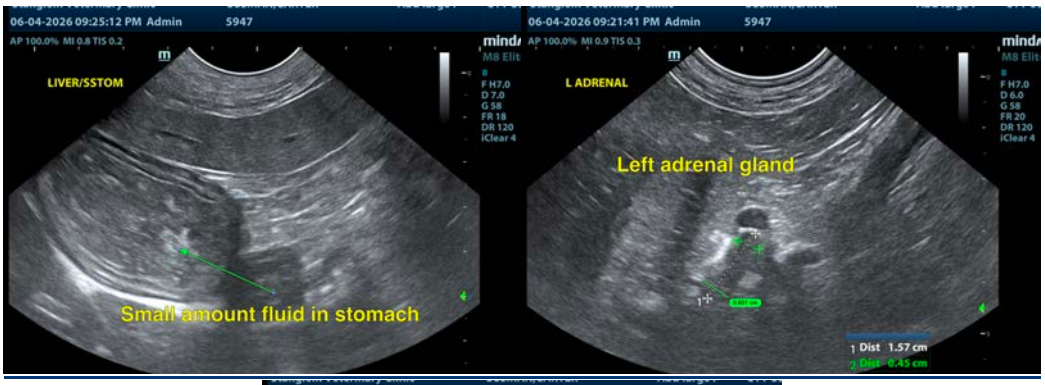

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com